MPORTANT: This is a fixed indemnity policy,
NOT health insurance

This fixed indemnity policy may pay you a limited dollar amount if you're sick or hospitalized. You're still responsible for paying the cost of your care.

- The payment you get isn't based on the size of your medical bill.
- There might be a limit on how much this policy will pay each year.
- This policy isn't a substitute for comprehensive health insurance.
- Since this policy isn't health insurance, it doesn't have to include most Federal consumer protections that apply to health insurance.

Looking for comprehensive health insurance?

- **Visit HealthCare.gov** or call **1-800-318-2596** (TTY: 1-855-889-4325) to find health coverage options.
- To find out if you can get health insurance through your job, or a family member's job, contact the employer.

Questions about this policy?

- For questions or complaints about this policy, contact your State Department of Insurance. Find their number on the National Association of Insurance Commissioners' website (**naic.org**) under "Insurance Departments."
- If you have this policy through your job, or a family member's job, contact the employer.

Employee Name _____ Social Security #_____

INSURANCE ENROLLMENT FORM

Please use this form to apply for coverage. Simply fill in any missing information below. Don't forget to include your Social Security Number, Birthdate, sign your name and enter today's date.

Cigna Health and Life Insurance Company

Employer: Archdiocese of Baltimore

ALL ABOUT YOU – THE EMPLOYEE

Your Name _____ Social Security # _____ Birthdate _____

Address _____ City _____ State _____ Zip _____

Email _____ Phone _____ Employee ID # _____ Gender _____

COMPLETE THIS SECTION ONLY IF YOU WANT COVERAGE FOR YOUR SPOUSE*

☐ I am currently married and my date of marriage is: _____

Name _____ Social Security # _____ Birthdate _____ Gender ___

YOUR COVERAGE ELECTIONS

Employee-Paid (Voluntary) Critical Illness Insurance – Policy # CI112332

Choose an amount and who you would like to include in your coverage. See the Summary of Benefits for costs.

	Coverage Amount	Acceptance
☐ Employee Only ☐ Employee + Spouse/Domestic Partner ☐ Employee + Children ☐ Employee + Family # of covered children ____	☐ $10,000 ☐ $20,000**	☐ Accept Coverage ☐ Decline Coverage

*If elected, Spouse and Child(ren) receive a percentage of employee elected coverage amount. **This is the Guarantee coverage amount. You may elect up to this amount during this enrollment. If you elect an amount greater than the Guarantee Coverage Amount you will be required to complete an Evidence of Insurability form.*

Accidental Injury Insurance – Policy # AI112415

Choose the plan and who you would like to include in your coverage. See the Summary of Benefits for costs.

	Plan	Acceptance
☐ Employee Only ☐ Employee + Spouse/Domestic Partner ☐ Employee + Children ☐ Employee + Family # of covered children ____	☐ Plan 1 ☐ Plan 2	☐ Accept Coverage ☐ Decline Coverage

Hospital Care Insurance – Policy # HC111946

Choose the plan and who you would like to include in your coverage. See the Summary of Benefits for costs.

	Plan	Acceptance
☐ Employee Only ☐ Employee + Spouse/Domestic Partner ☐ Employee + Children ☐ Employee + Family # of covered children ____	☐ Plan 1 ☐ Plan 2	☐ Accept Coverage ☐ Decline Coverage

*For purposes of this brochure, wherever the term Spouse appears, it shall also include Domestic Partner and Domestic Partners registered under any state which legally recognizes Domestic Partnerships or Civil Unions. Additional information is available from your Benefit Service Representative.

For California Residents: By signing below, I certify that I and my dependents for whom I am applying for coverage are currently covered for comprehensive health benefits from an insurance policy, an HMO policy, or an employer health benefit plan. Anyone who is not currently covered for comprehensive health benefits is NOT eligible for Critical Illness and/or Hospital Care coverage.

Maryland residents: Caution: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit, or who knowingly or willfully presents false information in an application for insurance, is guilty of a crime and may be subject to fines and confinement in prison.

Employee Name _____ Social Security #_____

Oregon residents: Caution: Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any fact material thereto; commits a fraudulent insurance act may be guilty of fraud and may be subject to civil or criminal penalties if intentional and material to the risk.

Vermont residents: Caution: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

SIGN HERE TO ACCEPT DEDUCTION FROM YOUR PAYCHECK

I accept the insurance options chosen above. If premiums are to be paid by payroll, I authorize my employer to deduct the necessary amounts from my paycheck. If I did not choose coverage now, and I decide I want coverage at a later date, I may be required to provide evidence of insurability at my own expense. I also understand that coverage for each of my dependents will go into effect only if the person is not confined in a hospital or institution or receiving certain medical treatment. I understand my information is protected by privacy laws and will be released only in accordance with these laws. Additional information about the rules and conditions around the requested insurance is described in the policy and certificate. Insurance benefits are underwritten by Cigna Health and Life Insurance Company.

Please Sign Here ☛ Signature _____ Date _____